CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

APPLICATION FOR PROFESSIONAL COUNSELOR OF MENTAL HEALTH LICENSURE

INSTRUCTION SHEET

Please read all instructions carefully before completing and submitting your application. Failing to follow instructions may delay your licensure. All auxiliary forms you need are included in this packet.

If your application is not complete within six months of filing, it may be considered abandoned and discarded.

Requirements for *All* Applications

☐ Submit completed, signed and notarized *Application for Professional Counselor of Mental Health Licensure*.
- Applications that are incomplete, unsigned or not notarized will be rejected.

☐ Enclose the processing fee by check or money order made payable to the "State of Delaware."
- Applications not accompanied by the required fee will be rejected.

☐ Arrange for the Board office to receive verification of your examination scores and certification as follows:
- If you are certified by the National Board for Certified Counselors (NBCC) or the Academy of Clinical Mental Health Counselors (ACMHC), follow the instructions for requesting score verifications on the NBCC website at www.nbcc.org.
- If you are certified by another national mental health specialty, arrange for the Board office to receive a *National Certifying Organization Certification Form* sent *directly* from the certifying organization to the Board office. Follow the instructions on the form. Note that the organization must be acceptable to the Board. For more information on certifying organizations, see Section 2.1.1.1 of the Board's Rules and Regulations.

☐ Arrange for the Board office to receive a verification of licensure from each jurisdiction where you now hold, or have *ever* held, a license to practice as a mental health professional.
- You may use the *Verification of Licensure* form enclosed with this packet to request the verification.

Requirements for Applications by *Certification*

If you are applying by certification instead of reciprocity, you must submit documentation of your mental health counseling education and post-Masters mental health counseling experience in addition to the requirements listed above. **Both you and your supervisor(s) should carefully follow the instructions for completing the required forms. *Incomplete or incorrectly completed forms delay processing of your application*. A resume will not be accepted in lieu of or in addition to the forms.**

☐ Arrange for the Board office to receive an official transcript showing your completed graduate degree, sent *directly* from the college/university to the Board office.

☐ If you have 30 post-Masters credit hours in the field of counseling, arrange for the Board office to receive an official transcript showing these graduate credits, sent *directly* from the school(s) to the Board office.
- You may substitute these credit hours for up to 1600 of the 3200 hours of the required post-Masters mental health counseling experience.

Professional Counselor of Mental Health

POST-MASTERS MENTAL HEALTH COUNSELING EXPERIENCE REQUIREMENTS

When applying by certification, you must arrange for the Board office to receive verification that you have provided the required hours of post-Masters mental health counseling. The following definitions apply to this requirement:

- Mental health counseling means face-to-face interaction with clients and other matters directly related to the treatment of clients in a professional mental health clinical counseling setting.
- Direct supervision means overseeing the supervisee's application of clinical counseling principles, methods or procedures to assist individuals in achieving more effective personal and social adjustment.
- An approved clinical supervisor must be a licensed professional counselor of mental health, licensed marriage and family therapist, licensed clinical social worker, licensed clinical psychologist, or licensed physician specializing in psychiatry. Certified school counselors and certified school psychologists are not approved clinical supervisors.

For more information about the experience requirements, refer to Sections 2.1.3 and 2.1.4 of the Board's Rules and Regulations available at www.dpr.delaware.gov.

1. You are required to have provided a total of ***at least 1600 hours*** of ***post-Masters mental health counseling*** while under the ***direct supervision*** of one or more ***approved clinical supervisors***. When combined, the hours of supervision under all approved clinical supervisors must span a period of *at least two but not more than four years*.
   - When totaled, at least 100 of the 1600 hours of direct supervision under all approved clinical supervisors must be face-to-face sessions between you and your supervisor.
   - When totaled, at least 60 of the 100 hours of direct supervision under all approved clinical supervisors must be face-to-face one-on-one – that is, you and your supervisor. The remaining 40 may be in a group setting – that is, you, your supervisor, and up to five other supervisees.

2. Whether any further documentation of hours of post-Masters experience is required depends on whether you have completed 30 post-Masters credit hours in the field of counseling.

IF you have…	THEN…
completed 30 post-Masters credit hours in the counseling field	no further documentation of post-Masters experience is required other than an official transcript, sent directly from the school(s), showing that you have completed the credit hours.
not completed 30 post-Masters credit hours in the counseling field	your clinical or administrative supervisor(s) must verify that you have provided additional hours of post-Masters mental health counseling. These hours, when added to the 1600 or more hours of direct supervision verified by your clinical supervisor(s), must total at least 3200 hours.

Example: You do not have 30 post-Masters credit hours in the counseling field. Your clinical supervisor verifies that you have provided 2200 hours of mental health counseling under his *direct supervision.* Since you do not have 30 post-Masters credit hours, your administrative or clinical supervisor must also verify that you have provided at least 1000 additional hours of mental health counseling. All 3200 hours must be within a period of not less than two years but no more than four years.

☐ To verify the minimum 1600 hours of direct supervision, arrange for the Board office to receive one or more *Direct Supervision Reference Forms* completed and signed by your **approved clinical supervisor(s)**. The forms must be mailed *directly* from the supervisor(s) to the Board office.

☐ If you do not have 30 post-Master credit hours, you must arrange for the Board office to receive one or more *Professional Counseling Experience* forms to verify the experience that you gained when you were not under the direct supervision of a clinical supervisor.

- For experience while you were employed, arrange for your clinical or administrative supervisor(s) to complete and mail one or more *Professional Counseling Experience-Employment* forms *directly* to the Board office.
- For experience while you were self-employed, arrange for a professional colleague, supervisor or other individual who has personal knowledge of your professional practice while self-employed to complete and mail one or more *Professional Counseling Experience-Self-Employment* forms *directly* to the Board office. The person who attests to your experience while self-employed cannot be related to you as a spouse, former spouse, parent, step-parent, grand-parent, child, step-child, sibling, aunt, uncle, cousin or in-law.

- All *Professional Counseling Experience* forms must clearly state ***the total number of post-Master's mental health counseling hours*** that you have provided. Providing only the dates of your employment or self-employment is not sufficient.
- **When combined, the mandatory 1600 hours verified on the *Direct Supervision Reference* forms added to the hours verified on all of the *Professional Counseling Experience-Employment* and *Professional Counseling Experience-Self-Employment* forms must total at least 3200 hours. *All* of these hours must span a period of not less than two but no more than four years**.

Additional Requirements for Applications by *Reciprocity*

Whether or not documentation in addition to that listed in the **Requirements for *All* Applicants** section above is required depends on whether you have been licensed in good standing for five years in any of the other jurisdictions where you hold a *current* license.

- If you have been licensed in good standing for five years in any other jurisdiction where you now hold a current license, no further documentation is needed.
- If you have been licensed less than five years in each individual jurisdiction where you are currently licensed, submit copies of the other jurisdictions' licensing statute and rules and regulations for the Board to review. The Board will determine if any of the other jurisdiction's statute/rules and regulations are substantially similar to those of Delaware.

If you apply by reciprocity with less than five years of practice in any other jurisdiction and the Board subsequently determines that none of the other jurisdictions' requirements are substantially similar to those of Delaware, you will be asked to provide the additional documentation of your counseling education and experience as listed in the **Requirements for Applications by *Certification*** section above. The Board will then consider you for licensure by certification. If you do not meet the requirements for licensure by certification, you may apply for the Associate Counselor of Mental Health license.

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

APPLICATION FOR PROFESSIONAL COUNSELOR OF MENTAL HEALTH LICENSURE

TYPE OF APPLICATION

1. Select the type of application you are filing (check one):

   ☐ Certification – I am currently certified by the National Board for Certified Counselors (NBCC), the Academy of Clinical Mental Health Counselors (ACMHC) or other national mental health specialty certifying organization.

   ☐ Reciprocity – I hold a *current* Professional Counselor of Mental Health license in another State, the District of Columbia or U.S. territory.

IDENTIFYING AND CONTACT INFORMATION – *All* applicants complete this section.

2. Full Name: _____ _____ _____
   Last First Middle

3. Other Names Used: _____ _____ _____

4. Mailing Address: _____

   _____ _____ _____
   City State Zip

5. Phone: _____ _____ Email: _____
   Home Work

6. Date of Birth (month/day/year): _____

7. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐
   - If yes, enter your SSN: _____
   - If no, you must file a *Request for Exemption from Social Security Number Requirement*.

NATIONAL CERTIFICATION – *All* applicants complete this section.

8. Do you hold current certification from the NBCC, ACMHC or other national mental health specialty? Yes ☐ No ☐
   If yes, complete the following information about your certification(s):

Certifying Organization	Certification Number	Date Certified	Expiration Date
NBCC			
ACMHC			
Other: _____			

If you are certified by NBCC or ACMHC, arrange for the Board office to receive verification of your examination scores and certification sent *directly* from the organization. If you are certified by another national mental health specialty, arrange for the Board office to receive a *National Certifying Organization Certification Form* sent *directly* from the certifying organization to the Board office.

LICENSURE HISTORY – *All* applicants complete this section.

9. Have you ever held a license to practice as a mental health professional in any jurisdiction other than Delaware? Yes ☐ No ☐ If yes, enter the following information about *each* mental health license that you have *ever* held.

JURISDICTION	TYPE OF LICENSE HELD	LICENSE NUMBER	LICENSURE DATES	
			From	To

- **Arrange for the Board office to receive a verification of licensure from *each* jurisdiction where you have *ever* held a mental health professional license.**
- **If you have held *none* of the *active* licenses listed for *five or more years*, arrange for the Board office to receive a copy each jurisdiction's law and regulations to be compared to those of Delaware.**

10. Have you ever been denied licensure in any other jurisdiction? Yes ☐ No ☐ If yes, explain fully: _____

_____

GRADUATE EDUCATION – Only applicants *by certification* complete this section. If applying by reciprocity, skip to the **DISCLOSURES** section.

11. Have you earned a Master's or higher post-graduate degree in a counseling or behavioral science field? Yes ☐ No ☐ If yes, enter this information about the program from which you received the highest degree.

Highest Degree Received: _____ Degree Date: _____

Institution Name: _____

Address: _____ _____ _____ _____
Street City State Zip

Arrange for the Board office to receive an official transcript sent *directly* from the school to the Board office.

PROFESSIONAL CLINICAL EXPERIENCE – Only applicants *by certification* complete this section. If applying by reciprocity, skip to the **DISCLOSURES** section.

12. Do you have 30 post-Masters credit hours in the counseling field? Yes ☐ No ☐ If yes, complete the following information about your post-Masters credit hours:

Educational Institution: _____

Dates: _____ _____ Number of Credits Earned: _____
From To

Arrange for the Board office to receive an official transcript showing these graduate credits, sent *directly* from the school(s) to the Board office.

13. On the next page, list your post-Master's professional clinical counseling experience. Begin with your most recent experience and work backward. When listing your experience, remember…
    - If you do not have 30 post-Masters credit hours (Question 12), ***all*** of the experience you list should ***total at least 3200 hours***. If you have 30 post-Masters credit hours, ***all*** of the experience you list should ***total at least 1600 hours***.
    - The dates of ***all*** of the employment and self-employment experience you list must span ***at least two years but no more than four years***.
    - In Total Number of Hours, calculate and enter how many hours of ***actual mental health counseling*** you provided during that period. Answers such as "40 hours/week" will not be accepted.

If you need more room, you may copy this page.

PERIOD FROM _____ **TO** _____ **TOTAL NUMBER OF HOURS**: _____

During this period, I was (check one): ☐ Employed—Position: _____

☐ Self-Employed—Title: _____

Employer Name (DBA if self-employed): _____

Address: _____

_____ _____ _____
City State Zip

Business Phone: _____ Email: _____

Supervisor Name: _____ Title/Professional Status: _____

Job Responsibilities and Activities: _____

_____

_____

_____

PERIOD FROM _____ **TO** _____ **TOTAL NUMBER OF HOURS**: _____

During this period, I was (check one): ☐ Employed—Position: _____

☐ Self-Employed—Title: _____

Employer Name (DBA if self-employed): _____

Address: _____

_____ _____ _____
City State Zip

Business Phone: _____ Email: _____

Supervisor Name: _____ Title/Professional Status: _____

Job Responsibilities and Activities: _____

_____

_____

_____

To verify the required 1600 hours of direct supervision, arrange for the Board office to receive *Direct Supervision Reference* forms completed and signed by your clinical supervisor(s) and mailed *directly* to the Board office. If you do <u>not</u> have 30 post-Masters credit hours (Question 12), arrange for the Board office to also receive *Professional Counseling Experience* forms—*Employment* or *Self-Employment* versions, as applicable—to verify the remaining hours of the required 3200 total hours of experience. See Instruction Sheet for information on who must complete and sign *Professional Counseling Experience* forms.

14. List each current or former clinical supervisor who will be verifying the required 1600 hours of direct supervision.

Name	Address	Phone/Email

DISCLOSURES – *All* applicants complete this section.

15. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction, including any offense for which you have received a pardon? Yes ☐ No ☐ If yes, arrange for the Board office to receive a certified copy of your criminal history record.

16. Have you received any administrative penalties regarding your actions as a licensed, registered or certified mental health provider, including but not limited to fines, formal reprimands, license suspensions or revocation (except for license revocations for nonpayment of license renewal fees), probationary limitations, and/or have you entered into any "consent agreement" which contains conditions placed by a Board on your professional conduct, including any voluntary surrender of a license? Yes ☐ No ☐ If yes, attach a detailed explanation of all such penalties.

17. Are any disciplinary actions pending against you? Yes ☐ No ☐ If yes, attach a detailed explanation of any pending actions.

18. Have you done any of the following grounds for discipline?
    - committed or knowingly cooperated in a fraud or material deception in order to acquire a license
    - impersonated another person holding a license
    - allowed another person to use your license
    - aided or abetted an unlicensed person to represent himself or herself as a licensee?

    Yes ☐ No ☐ If yes, attach a detailed explanation of the violations.

19. Do you currently excessively use or abuse drugs or have you done so in the past 3 years? Yes ☐ No ☐ If yes, attach a detailed explanation.

20. Have you engaged in an act which involved consumer fraud or deception, restraint of competition, or price fixing? Yes ☐ No ☐ If yes, attach a detailed explanation.

21. Do you have any impairment related to drugs or alcohol or a finding of mental incompetence by a physician that would limit your ability to act as a professional counselor of mental health or associate counselor of mental health in a manner consistent with the safety of the public? Yes ☐ No ☐ If yes, attach a detailed explanation.

22. Have you been penalized for any willful violation of the code of ethics adopted by the Board, the NBCC code of ethics or other similar professional mental health counseling standard? Yes ☐ No ☐ If yes, attach a detailed explanation.

23. Are you presently in violation of any Rule and Regulation set forth by the Delaware Board of Mental Health and Chemical Dependency Professionals? Yes ☐ No ☐ If yes, attach a detailed explanation of all such violations.

To assure consideration of your license application at the next Board meeting, the Board office must receive all of these items <u>no later than</u> 4:30 PM ten full working days before the Board's meeting date:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not <u>complete</u> within six (6) months of filing may be considered abandoned and discarded.

Please note: When your application is <u>complete</u>, please allow 4-8 weeks to receive your license.

AFFIDAVIT

The undersigned applicant for Licensed Professional Counselor of Mental Health or Licensed Associate Counselor of Mental Health, being sworn, deposes and affirms that he or she is the person who executed this application; that the statements contained on this application are true in every respect; that he or she has not suppressed or withheld information that might affect this application; that he or she will abide by the laws and the ethical standards of this profession; and that he or she has read and understands this statement.

The applicant authorizes all jurisdictions to release any and all information regarding his/her disciplinary history and current status to the Delaware Board of Mental Health and Chemical Dependency Professionals.

Signature of Applicant: _____ Date: _____

State of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____2_____.

Signature of Notary: _____

SEAL

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

DIRECT SUPERVISION REFERENCE FORM
PROFESSIONAL COUNSELOR OF MENTAL HEALTH LICENSURE

INSTRUCTIONS

The purpose of this form is to verify the ***hours of post-Masters mental health counseling*** that an applicant has provided while under the ***direct supervision*** of an ***approved clinical supervisor***. This form is not required for applicants applying by reciprocity.

Please follow these instructions for completing this form. ***Incomplete or incorrectly completed forms delay processing of the application.*** The clinical supervisor must complete the entire form, sign it and mail it *directly* to the Board office at the address above. The applicant is not to complete any portion of the form. Forms not received *directly* from the supervisor will not be accepted.

In completing this form, the following definitions apply:

- Mental health counseling means face-to-face interaction with clients and other matters directly related to the treatment of clients in a professional mental health clinical counseling setting.
- Direct supervision means overseeing the supervisee's application of clinical counseling principles, methods or procedures to assist individuals in achieving more effective personal and social adjustment.
- An approved clinical supervisor must be a licensed professional counselor of mental health, licensed marriage and family therapist, licensed clinical social worker, licensed clinical psychologist, or licensed physician specializing in psychiatry. Certified school counselors and certified school psychologists are not approved clinical supervisors.

Applicants are required to have provided a total of at least 1600 hours of post-Masters mental health counseling while under the direct supervision of one or more approved clinical supervisors. When combined, the hours of supervision under all approved clinical supervisors must span a period of *at least two but not more than four years*.

- When totaled, at least 100 of the 1600 hours of direct supervision under all approved clinical supervisors must be face-to-face sessions between the applicant and supervisor.
- When totaled, at least 60 of the 100 hours of direct supervision under all approved clinical supervisors must be face-to-face one-on-one – that is, applicant and supervisor. The remaining 40 may be in a group setting – that is, the applicant, the supervisor, and up to five other supervisees.

For more information about the direct supervision requirements, refer to Section 2.1.4 of the Board's Rules and Regulations available at www.dpr.delaware.gov.

INFORMATION ABOUT CLINICAL SUPERVISOR

1. Applicant Name: _____ _____ _____
   Last First Middle

2. Supervisor Name: _____ _____ _____
   Last First Middle

3. Provide the following information about your professional licensure:

✓	LICENSES HELD (check all that apply)	STATE	LICENSE #	ISSUE DATE
☐	Professional Counselor of Mental Health			
☐	Clinical Social Worker			
☐	Marriage and Family Therapist			
☐	Clinical Psychologist			
☐	Psychiatrist			

4. Supervisor's Practice Name (if applicable): _____

5. Practice Address: _____

_____ _____ _____
City State Zip

6. Phone: _____ Email: _____

DIRECT SUPERVISION HOURS

7. Did you provide ***direct supervision,*** as defined above, to the applicant? Yes ☐ No ☐ If no, skip to the **Signature**.

8. Enter the dates of post-Master's clinical experience that the applicant provided while under your direct supervision:

   From _____ To _____
   Month/Year Month/Year

   <u>Alert</u>: This period must not span more than four years.

9. During this period, how many total hours of mental health counseling did the applicant provide while under your direct supervision? _____

   <u>Alert</u>: Calculate and enter a total number of hours. Answers such as "40 hours/week" will <u>not</u> be accepted.

10. During this period, how many total hours of face-to-face, individual (one-on-one) supervision did you provide to the applicant? _____

11. During this period, how many total hours of face-to-face, group supervision did you provide to the applicant? _____

CERTIFICATION

I certify that I have personally completed all sections of this form and that the information provided herein is accurate and complete to the best of my knowledge.

Clinical Supervisor Signature: _____ Date: _____

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

PROFESSIONAL COUNSELING EXPERIENCE FORM – EMPLOYMENT
PROFESSIONAL COUNSELOR OF MENTAL HEALTH

INSTRUCTIONS

The purpose of this form is to verify the hours of post-Masters mental health counseling that an employed applicant provided ***in addition to*** the mandatory minimum 1600 hours under direct supervision of an approved clinical supervisor. This form is not required when the applicant has 30 post-Masters credit hours in the field of counseling or is applying by reciprocity.

Please follow these instructions for completing this form. ***Incomplete or incorrectly completed forms delay processing of the application.*** The clinical or administrative supervisor must complete the entire form, sign it and mail it *directly* to the Board office at the address above. The applicant is not to complete any portion of the form. Forms not received *directly* from the supervisor will not be accepted.

In completing this form, the following definitions apply:

- Mental health counseling means face-to-face interaction with clients and other matters directly related to the treatment of clients in a professional mental health clinical counseling setting.
- Direct supervision means overseeing the supervisee's application of clinical counseling principles, methods or procedures to assist individuals in achieving more effective personal and social adjustment.
- An approved clinical supervisor must be a licensed professional counselor of mental health, licensed marriage and family therapist, licensed clinical social worker, licensed clinical psychologist, or licensed physician specializing in psychiatry. Certified school counselors and certified school psychologists are not approved clinical supervisors.

Applicants who do not have 30 post-Masters credit hours in the counseling field are required to have provided a total of 3200 hours of post-Masters mental health counseling.

- Of the 3200 hours, 1600 or more must be the mandatory hours of direct supervision by an approved clinical supervisor. Hours of direct supervision are verified on the *Direct Supervision Reference* form. Do not enter direct supervision hours on *Professional Counseling Experience* forms.
- On the *Professional Counseling Experience* form, enter only hours that were not under the direct supervision of an approved clinical supervisor.
- For hours provided while self-employed, use the *Professional Counseling Experience Form-Self Employment*.
- All 3200 hours, including the mandatory minimum 1600 hours of direct supervision, must be provided over a period of ***at least two but not more than four years***.

For more information about the experience requirements, refer to Section 2.1.3 of the Board's Rules and Regulations available at www.dpr.delaware.gov.

INFORMATION ABOUT SUPERVISOR

1. Applicant Name: _____ _____ _____
   Last First Middle
2. Supervisor Name: _____ _____ _____
   Last First Middle
3. Check type of supervision you provided to the applicant: ☐ Clinical ☐ Administrative
4. Supervisor's Practice Name (if applicable): _____

5. Practice Address: _____

_____ _____ _____
City State Zip

6. Phone: _____ Email: _____

EXPERIENCE HOURS

7. Enter the period when you supervised the applicant:

   From _____ To _____
   Month/Year Month/Year

   Alert: This period must not span more than four years.

8. During this period, how many total hours of mental health counseling did the applicant provide while not under direct supervision of an approved supervisor? _____

   Alert: Calculate and enter a total number of hours. Answers such as "40 hours/week" will not be accepted.

9. Describe the practice, agency, or setting where the applicant worked during the period above. (Examples include group practice, community mental health agency, elementary school, etc.)

   _____

   _____

   _____

CERTIFICATION

I certify that I have personally completed all sections of this form and that the information provided herein is accurate and complete to the best of my knowledge.

Supervisor Signature: _____ Date: _____

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

PROFESSIONAL COUNSELING EXPERIENCE FORM – SELF-EMPLOYMENT
PROFESSIONAL COUNSELOR OF MENTAL HEALTH

INSTRUCTIONS

The purpose of this form is to verify the hours of post-Masters mental health counseling that a self-employed applicant provided ***in addition to*** the mandatory minimum 1600 hours under direct supervision of an approved clinical supervisor. This form is not required when the applicant has 30 post-Masters credit hours in the field of counseling or is applying by reciprocity.

Please follow these instructions for completing this form. ***Incomplete or incorrectly completed forms delay processing of the application.*** The clinical or administrative supervisor must complete the entire form, sign it and mail it *directly* to the Board office at the address above. The applicant is not to complete any portion of the form. Forms not received *directly* from the supervisor will not be accepted.

In completing this form, the following definitions apply:

- Mental health counseling means face-to-face interaction with clients and other matters directly related to the treatment of clients in a professional mental health clinical counseling setting.
- Direct supervision means overseeing the supervisee's application of clinical counseling principles, methods or procedures to assist individuals in achieving more effective personal and social adjustment.
- An approved clinical supervisor must be a licensed professional counselor of mental health, licensed marriage and family therapist, licensed clinical social worker, licensed clinical psychologist, or licensed physician specializing in psychiatry. Certified school counselors and certified school psychologists are not approved clinical supervisors.

Applicants who do not have 30 post-Masters credit hours in the counseling field are required to have provided a total of 3200 hours of post-Masters mental health counseling.

- Of the 3200 hours, 1600 or more must be the mandatory hours of direct supervision by an approved clinical supervisor. Hours of direct supervision are verified on the *Direct Supervision Reference* form. Do not enter direct supervision hours on *Professional Counseling Experience* forms.
- For hours provided while you were employed, use the *Professional Counseling Experience Form- Employment*.
- The person completing this form to attest to the applicant's experience must be a professional colleague, supervisor or other individual who has personal knowledge of the applicant's professional practice while self-employed. This person cannot be related to the applicant as a spouse, former spouse, parent, step-parent, grand-parent, child, step-child, sibling, aunt, uncle, cousin or in-law.
- All 3200 hours, including the mandatory minimum 1600 hours of direct supervision, must be provided over a period of ***at least two but not more than four years***.

For more information about the experience requirements, refer to Section 2.1.3 of the Board's Rules and Regulations available at www.dpr.delaware.gov.

INFORMATION ABOUT PERSON ATTESTING TO EXPERIENCE

1. Applicant Name: _____ _____ _____
   Last First Middle

2. Your Name: _____ _____ _____
   Last First Middle

3. Do you have personal knowledge of the extent of the applicant's professional practice while he or she was self-employed? Yes ☐ No ☐ If yes, explain your professional relationship to the applicant: _____

_____

_____

4. Are you related to the applicant as a spouse, former spouse, parent, step-parent, grand-parent, child, step-child, sibling, aunt, uncle, cousin or in-law? Yes ☐ No ☐ If yes, specify relationship: _____

5. Your Address: _____

_____ _____ _____
City State Zip

6. Phone: _____ Email: _____

EXPERIENCE HOURS

7. Enter the period of the applicant's experience of which you have personal knowledge:

   From _____ To _____
   Month/Year Month/Year

   Alert: This period must not span more than four years.

8. During this period, how many total hours of mental health counseling did the applicant provide while not under direct supervision of an approved supervisor? _____

   Alert: Calculate and enter a total number of hours. Answers such as "40 hours/week" will not be accepted.

CERTIFICATION

I certify that I have personally completed all sections of this form and that the information provided herein is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

VERIFICATION OF LICENSE

Send a separate form to *each* jurisdiction other than Delaware where you have ever held a license to practice as a mental health practitioner. Before sending this form to the jurisdiction, it is advisable to find out if the jurisdiction requires a fee to provide a license verification. You may duplicate this form.

This section to be completed by applicant.	Last Name:_____ First:_____ Middle: _____ SSN:_____ Date of Birth:_____ Other Name(s) Used: _____ Jurisdiction Where LIcensed: _____ License/Registration Number(s) in Jurisdiction Named Above: _____ I am applying for Delaware licensure as a: ☐ Professional Counselor of Mental Health ☐ Associate Counselor of Mental Health ☐ Chemical Dependency Professional ☐ Marriage and Family Therapist ☐ Associate Marriage and Family Therapist Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the Delaware Board of Mental Health and Chemical Dependency Professionals. **Applicant Signature:** _____ Date: _____
This section to be completed by Licensing Authority.	Our records indicate that the applicant named above was licensed in the State/Province/Jurisdiction of: _____ as a (type of license) _____ Registration/License Number: _____ Issue Date (mm/dd/yyyy): _____ Expiration Date (mm/dd/yyyy): _____ Has the licensee ever been subject to any disciplinary action or had his/her license revoked or suspended? Yes ☐ No ☐ **If yes, please enclose a certified copy of the board's final order with this license verification.** Are any disciplinary proceedings or unresolved complaints pending against the licensee? Yes ☐ No ☐
AFFIX OFFICIAL SEAL HERE	***I certify that the statements contained herein are true and correct.*** Printed Name of Official: _____ Signature of Official: _____ Date: _____ Title:_____ Phone: _____ Fax: _____ Email:_____

Return completed, signed and sealed form *directly* to the Board office at the address above.

Revised 11/2009

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

CERTIFYING ORGANIZATION CERTIFICATION FORM

The applicant below has applied for Delaware licensure as a mental health professional. This form elicits information about the applicant's certification issued by a national mental health specialty *other than* the National Board for Certified Counselors or the Academy of Clinical Mental Health Counselors.

INFORMATION ABOUT APPLICANT – Applicant completes this section and sends to certifying organization.

1. Full Name: _____ _____ _____
   Last First Middle
2. Mailing Address: _____

   _____ _____ _____
   City State Zip
3. Phone: _____ _____ Email: _____
   Home Work
4. Certifying Organization Name: _____

   Certified as: _____ Certification No. _____

   Date Certified: _____ Expiration Date: _____

I hereby authorize the certifying agency named above to release information regarding my certification to the Delaware Board of Mental Health and Chemical Dependency Professionals.

Applicant Signature: _____ Date:_____

INFORMATION ABOUT CERTIFYING ORGANIZATION – Official of certifying organization completes this section and mails *directly* to the Board office at the address in the letterhead.

1. Name of Certifying Organization: _____
2. Address: _____

   _____ _____ _____
   City State Zip
3. Is the applicant currently certified as represented above? Yes ☐ No ☐
4. Is the applicant currently in good standing? Yes ☐ No ☐ If no, please explain: _____

   _____
5. To enable the Delaware Board to evaluate the applicant's certification, please enclose the following documents:

   ☐ Statement of Mission and Scope of Membership
   ☐ Membership Requirements
   ☐ Description of Membership Examination
   ☐ Code of Ethics for Members

Signature of Official: _____ Date: _____

Printed Name of Official: _____ Title: _____